SUBMIT 1 COPY TO DEPARTMENT OF FINANCE & PAYROLL OFFICE

WORKERS' COMPENSATION – SUPPLEMENTARY FORM
EMPLOYEE INFORMATION
ON-THE-JOB INJURY ONLY

1. _____ _____ LOST NO TIME ( ) Check Here
   Department Dept. #

2. _____ Date of Injury _____
   Employee's Name (Last – Middle – First)

3. _____
   Social Security Number Paid: Wkly____ Bi-Wkly____

   AVERAGE Weekly Salary _____

4. _____ RATE per pay period _____
   Classification

   RATE per hour _____

   Scheduled hours per pay period _____ Scheduled off days_____

   Is employee disabled? _____ (If "yes", give last day WORKED)

   Last day WORKED_____

Signed_____ _____
Department Head Date

****

COMPLETE THIS SECTION ONLY AFTER EMPLOYEE RETURNS TO WORK

****

NOTE: If top section has already been submitted, complete only lines 1 through 4 of top section along with this section of the form.

Date employee returned to work _____

DO NOT WRITE BELOW THIS LINE – FOR PAYROLL DEPARTMENT USE ONLY

Date of hire _____

Pays retirement: yes/no (If no, effective date to pay _____)

FICA / non-FICA _____

Year – to – date _____

_____